Patient Information

Name: ____ DOB: ___________________
Social Security Number: _______________________________ Sex: M / F
Address:____
____
Home Phone: ___________________________ Cell Phone: ____________________________
Work Phone: ___________________________ Fax: __________________________________
Email address: ____
Marital Status: ___________________________

Insurance Information

Primary Insurance: ____
Subscriber Name: _______________________________________ DOB: _________________
Subscriber ID: ____

Secondary Insurance: ____
Subscriber Name: _______________________________________ DOB: _________________
Subscriber ID: ____

Emergency Contact

Emergency Contact Name: ____
Home Phone: _______________________________ Cell Phone: ______________________
Relationship to Patient: ____

Pharmacy Information

Pharmacy Name: ____
Phone Number: ______________________________ Fax: ____________________________
Address: ____

Rx History Consent: I hereby authorize Zand Medical Partners to obtain my previous prescription/medication history through external resources. ___________ (initials)

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The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to Zand Medical Partners. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any office visit copayment due at time of service and/or deductibles that may apply. If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original.

Print Name: ____

Signature: ____ Date: __________________